

United States District Court
District of Massachusetts

Colleen Hardacre,
Plaintiff

Civil Action
No. 05-10542-mlw

v.

Federal Bureau of
Investigation & U.S. Department
of Justice,
Defendants

Response to Motion to Dismiss

This response is being filed in response
to Defendants' Motion to Dismiss as follows:

interruption
because of FBI abuse +

1. While the Plaintiff filed another rambling, difficult to read, yet completely factually accurate Complaint in 2004 that was dismissed, the Plaintiff rewrote a Condensed completely intelligent, accurate, easy to read ^{complaint} with simple sentences demonstrating the wrong + criminal deductions, decisions + behavior of false Assessments going on that anyone able to read could comprehend. Additionally, the Plaintiff attached the necessary permission as requested in the 2004 Complaint to allow this 2005 completely true depiction of what the FBI is doing that is illegal to the Plaintiff.
2. The Plaintiff did not file a complaint sooner against the FBI because the FBI obstructed about 1000 phone calls + attempts to confront them, including a 7000 attorney bill because they "weren't ready". They are still "not ready" because they are operating on false accusations which will be proven with ~~sure~~ fact to be false, so they always need more time.

The Plaintiff has tried to confront the ~~FBI~~ since 1996, as outlined in my 2004 Motion for appointment of attorney.

3. The Plaintiff spoke to the US Attorney & was told the "FBI says they not surveilling or provoking you & have no Case Number associated with you".
The FBI is lying to infinity & has to
Because everything I complain they are doing, they are and it is illegal & not solving an actual crime of mine.
4. The Plaintiff asked the US Attorney, McDonato, if he is aware of the ~~FBI's~~ tap prodding tactics at all & what they do to police tape & violate a citizen & he replied "he has no idea what the FBI does!" Yet he is representing them & the FBI is watching this go on & allowing it. It seems that in the U.S. a government official representing them should be completely informed as to what they are defending & representing.

5. The FBI is a giant freakshow clown circus of power, money & control & get away with wrong daily. They use these tactics & then hide & not allow you access to them so it sounds like it's impossible, while it is completely, sadly true that they engage in this extreme unwarranted not appropriate means of abuse & false deduction. As expected, the FBI is denying their presence because every thing they are doing is illegal.
6. The FBI can lie & stalk & get away with this wrong for now, but I ensure the court ^{and} that these documents, especially my easy to read 100% true complaint in 2005 will be presented to the FBI when they stop hiding & they will be eventually facing all of my true accusations & wrongs & compensating me. I will continue to document everything they do to me until they "appear".

7. In response to this motion my comments are as follows.

With regard to postal, pie trucks, melons, etc: the FBI was implying I was involved in postal crime. I was not. This was illegal. They operate on themes & this was one of them.

With regard to discovery harassment, the FBI has tape about this 8 years ago & illegally continues to harass regarding this to date. This is illegal & excessive.

With regard to trigger & adrenaline comments it is very simple. Now follow along. The FBI uses noise & fight & fear trains & makes you ignorant & fearwards to coerce tape. Each of these, noise, fight & fear at presentment cause a fight or ~~or~~ response. This response creates abnormal adrenaline about 500-5000 & a day. After 4 years, your pelvic muscles (because they are smooth & skeletal) become contracted see Exhibit A

Mine were contracted by the FBI's ~~studies~~
 by 1999. The FBI continued to use tactic
 to this date + has my pelvis in
 complete contraction. See Exhibit B
 My latest 12/2004 EM & demonstrating
 no difference between rest (which is
 normal) + squeezing. This is from
 relentless FBI practice. Only the
chemical produced at provoke has done
this. The FBI has spent 5.5 more years
Contracting me on purpose to force tape
to blame me for producing adrenaline
during their tactic - during which
their fight, noise + fear is purposely
blamed on me for the sole purpose
of inducing adrenaline. Their tactic
consists of relentless noise + fight - which
constructs & is then ignored by them as
inducing chemical & fear which is
really only ignoring that which they
trained you to fear. A tug is a complete
 contraction of all pelvic muscles
 from adrenaline + is cumulative +
 damaging to muscle tone, cells, function
 + is painful. They have strength

About 11 million more times after crushing my pelvis at 8 million (2 million per year since 1995-6). They spent 6 years + all planning another year contracting me ~~what~~ what a really proactive response chemical to generate to blame me for their making me produce Adrenaline. My health is endangered & My pelvis has already torn 4 times This is why I want them to stop. Nothing & no one seems to be able to, not even federal court, which apparently they can control as everything. No citizen should be subjected to this. make them stop.

8. So far, the FBI has assessed the following, but this was true.

FBI

discovery - pedophile
for life
postal criminal

she's crazy/drugs.

Truth

discovery over in
Adolescence never
occurred again
I got stamps +
was already
surveilled & could
not have been
involved in crime

drug overdose 1
year in 1983 with
sensory nerve
damage due

FBI

I'm contracted
b/c I'm evil at
their prostate + its
not adrenaline
changing - per
treatment + implicates

Truth

nerve damage the
FBI forgot to tell me
about until 2003 but
implied I was nuts for
sensory nerve complaints

Their tactic figs,
noise + fear training
forced me to
secrete adrenaline
on cue, destroyed
my pelvis + they're
trying to blame me +
anyone besides
their prostate. They
know its adrenaline but
don't live it.

9 These are single statements + truths
about what the FBI has done
that is illegal + wrong + has harmed
me. They should not be allowed
any more time to harm my body or
not answer my accusations.

10 The FBI has crushed my pelvic muscles with proache adrenaline. Adrenaline contracts these muscles. See Exhibit 8

11 As part of the tactic that the FBI's Attorney does not know about is work, play, life + everywhere infiltration. That is what surveillance means.

12 It is quite coincidental that ^{my grandniece} she made a comment to me "You tick me in tonight" - which in FBI world would be a cue of molestation, and 8 hours later she was on the floor with ^(millions of games) stroke. I watched the FBI cue noise + fight + break machines, turn off utilities, break calls, etc. + time it at the world child or anything you can relate to their theme. Discovery was their theme. This is their tactic. their attorney does not know about. I watched this tactic take place timed at hundreds of things per day. I am not saying they for sure did something. I think it is

get another coincidence is that my boyfriend, his family, his other friends, & others I know look-alikes with a bent of a similar feature, etc are on TV, usually saying words related to our relationship, coincidentally.

Coincidental. Just like their theme was that my pelvis (which they monitor in some demented way) contracted 3 times & time later on 2 times. At their provoke is motion to the left in 2001. & this has been their deluded theme/bias for 4.5 years now. Coincidentally, my father was "supposedly" on United 175 that crashed into the twin towers (2 to the left) with 3 planes crashing into buildings & I almost but averted.

Their "case" since 2000 has been that they don't understand their fight & noise contract or their fear alarm, but they assure it did 5 times.

Really I provoke respond at their fear cue 1 million times per year & 1 million fights - with adrenaline. They operate on themes & their tactics involve direction, color, alphabet fear games, words, & numbers. Coincidentally, this is their theme.

13. Another coincidence is the FBI's harassing me re discovery and lauding at a peer in childhood/adolescence. At 17 I baled out for Rocky, a baby & did nothing wrong. Then 1st day of senior year a rock flew out of a machine & broke my hand. Coincidentally 6 months later my boyfriend & I baled out for Rocky (again doing nothing wrong) & just before we were supposed to be there his hand was

Conveniently crushed in a conveyor belt, just before we went there, coincides with the FBI has been screwing around with my life forever.

14 The remaining sentences in my 2005 Complaint are completely true & anyone could understand them & if not now, the FBI will be answering them when they stop hiding.

15 The FBI did not obstruct my sex drive, they crushed & contracted all of my bowel, bladder & vaginal muscles to tone, nerve, cell, lining & function damage & they wont stop, with proshake - their tactic. They harass everyone that sex, so sum it down as they cannot have ~~any~~ ^{any} more due to contraction ^{they don't care} everything.

16 I would also have an attorney following all procedural guidelines but the defendant, the FBI, will not let me.

17 Ripping my bladder, bowel & vaginal with Adrenalin tactic response could never be a frivolous Complaint. Neither is stealing 10 years of an

adult life over false deductions,
especially about the true science
consequence of the firsts reckless loss of
provoke, calling a non criminal a
pedophile over discovery, a terrorist over
getting a mowhawk + stamps, ^{or} crazy
when they really have nerve damage.

- 18 My life should not be further obstructed
by the FBI to force false lying +
substantiating a different theory
other than the truth going on of
blaming me for producing adrenaline
at their fight, noise + that which
they have forced me to perceive +
react to as a fear alarm. The purpose
of this is to spike adrenaline on cue.
The FBI has forgotten this 11 million
times now.
- 19 Producing adrenaline harming my
body is not my guilt or crime, it
is their fault + consequence + they
know it.

That is why they "not them".

20 Every word in this complaint is completely true + factual.

21 The statute of limitations was exceeded because the FBI would not, as ~~know~~^{at one}, have access to the law + has never stopped blatantly harassing since 1995 + for many years before then. There are people, and an attorney told me to, they harass for life, I am one of them.

22 Someone needs to stop the FBI before they cause a serious pelvic trauma or heart attack from adrenaline.

My life is endangered by more tactics. They do not need anymore time, they use the same exact tactics - 1 million hoists + fights + 1 million fears, using the exact same muscles per year. They are cumulatively contracted + have torn. Nothing they do is solving

A crime or changing this chemical from affecting the same muscles in the same way 10 million times & have felt + 8 million times putting this in place. They "arent there & arent ready" because they want tape forever about my reaction to substantiate a theory of how it not their fault & use of light, noise, timing or making the citizen ignore the fear (10 million times), except that is all that is going on & they know it. They are devious, conniving, scheming, lying about their tactics chemical consequence & breaking the law with their control & violation of my life. They are not solving a crime of mine. They don't want their provoke tactics to be the issue & have harmed a citizen, except it did. That's why they're still "not there & I am delusional".

The plaintiff respectfully requests that
should this Court dismiss this case
that it is without prejudice so that
when the FBI stops hiding & is finally

I forced to allow me to have an attorney
that my attorney is allowed to file a suit
against them that they have to acknowledge
& deserve & if what I am saying is true,
feds should not fear. No citizen should
have done to them what they did to me.
I cannot obviously prove the FBI is doing these
things until they are "ready" and appear.

Respectfully submitted,

6-7-05

Colleen Hardaway, pro se
113 River Pointe Way
#16209
Lawrence, MA 01843
978-683-3755

Certificate of Service

I certify that on this day a true copy of the plaintiff's Response to Motion to Dismiss was served by First Class Mail, postage prepaid, upon the defendants at the following address:

Michael J. Sullivan, Esq.
Christopher K. Donato, Esq.
U.S. Attorney's Office
John Joseph Moakley Courthouse
Courthouse Way, Suite 9200
Boston, MA 02290

Dated: 6/7/05

Colleen M. Hardace
Prose

113 RiverPointe Way
#6209
Lawrence, MA 01843
617-78-683-3755

Exhibit A

ANXIETY-PANIC-STRESS : THE ANXIETY RESPONSE

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ANXIETY-PANIC-STRESS
THE ANXIETY RESPONSE

"Our civilization is still in the middle stage: scarcely beast, in that it is no longer wholly guided by instinct; scarcely human, in that it is not yet wholly guided by reason." . . . Theodore Dreiser, "Sister Carrie", 1900

"Anxiety" is described in Merriam-Webster's Collegiate Dictionary as a "painful or apprehensive uneasiness of mind usually over an impending or anticipated ill, an abnormal and overwhelming sense of apprehension and fear often marked by physiological signs (as sweating, tension, and increased pulse), by doubt concerning the reality and nature of the threat, and by self-doubt about one's capacity to cope with it."

* * *

Anxiety is a normal emotional and physical response occurring when we become overwhelmed by the fear that something will happen that we may not be able to handle or that someone or something is taking away our control. The anxiety response is built in for purposes of survival. If we didn't have it, we wouldn't be able to meet deadlines or get out of danger. It is a response to an alarm message that we have sent to the subconscious part of our brain. This is not the rational part of our brains, the part with which we think, plan, and intellectualize. It is the part we share with animals, the part that is instinctive and which automatically monitors and runs our bodies, ensuring our physical survival. (See Dr. H. Benson's "The Relaxation Response".)

If we are in a life-and-death situation, the anxiety response is essential in providing us with the physical and emotional capability to "fight" off a mugger or "flee" from a runaway truck -- hence the name "fight-flight response". If we are not really in a short-term crisis situation, however, and that alarm message is not turned off, the adrenalin which has been pumped into our blood streams to help us react in a quick and powerful way, begins to destructively stress us our both physically and emotionally. It is then, that we are at risk for developing disorders that not only can affect our cardiological, gastrointestinal and musculoskeletal systems, but can also affect our emotional sense of well-being and our interpersonal dynamics and can result in our developing depression and/or one of the anxiety disorders discussed on this website.

emergency theory

A theory of the emotions, advanced by W.B. Cannon, that animal and human organisms respond to emergency situations by increased sympathetic nervous system activity including an increased catecholamine production with associated increases in blood pressure, heart and respiratory rates, and skeletal muscle blood flow.

heart rate from On-line Medical Dictionary

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heart rate

The number of beats per minute. Normal resting heart rates are variable with age, sex, size and overall cardiovascular condition. Heart rate can be determined by taking the pulse. Normal heart rate for an average sized adult is in the range of 60-85 beats/minute.

(27 Sep 1997)

Previous: [heart murmur](#), [heart murmurs](#), [heart muscle](#), [heartpea](#), [heart position](#), [heartquake](#)
Next: [heart rate](#), [foetal](#), [heartrending](#), [heart-robbing](#), [heart rupture](#)

adrenal gland

exact age or chronological limits in defining the adolescent period.

adolescent (ad'ō-lēs'ĕnt). 1. Pert. to adolescence. 2. Young man or woman not fully grown.

adoral (ad'ō-răl) [L. *ad*, to, + *or*, mouth]. Toward or near the mouth.

ADP. *adenosine diphosphate*.

adrenal (ad'renăl) [L. *ad*, to, + *ren*, kidney]. Originally used to indicate nearness to the kidney. Now used in reference to the adrenal gland or its secretions.

adrenal crisis. Acute adrenocortical insufficiency. CAUTION: Death due to circulatory collapse will result unless the condition is treated promptly and vigorously by instituting corticosteroid therapy. The cause may be a hemorrhage into the adrenal cortex as a result of infection or it may occur at birth, resulting from trauma. In the adult, headache, lassitude, confusion, restlessness, vomiting, and shock progressing to death occur if the cortex is destroyed. Relative adrenal insufficiency can occur in patients for two to three months after discontinuation of adrenocortical hormone therapy. Sudden stress, such as surgery or trauma, can produce a subacute form of adrenal crisis in these patients. SEE: Addison's disease; Waterhouse-Friderichsen syndrome.

adrenalectomy (ad'renăl-ĕk'tō-mē) [L. *ad*, to, + *ren*, kidney, + Gr. *ektome*, excision]. Excision of an adrenal gland.

adrenal gland. A triangular-shaped body covering the superior surface of each kidney. It is a gland of internal secretion. SYN: *suprarenal gland*. SEE: illus.

EMBRYOLOGY: The adrenal gland is essentially a double organ composed of an outer cortex and an inner medulla. The cortex arises in the embryo from a region of the mesoderm that also gives rise to the gonads, or sex organs. The medulla arises from ectoderm, which also gives rise to the sympathetic nervous system.

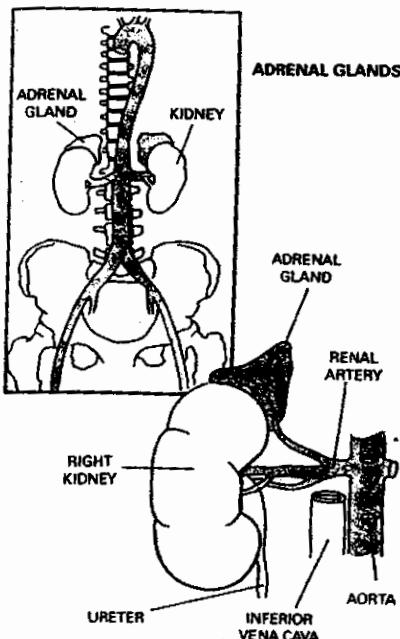
ANAT: The entire gland is enclosed in a tough connective tissue capsule from which trabeculae extend into the cortex. The cortex consists of cells arranged into three zones: the outer zona glomerulosa, the middle zona fasciculata, and the inner zona reticularis. The cells are arranged in a cordlike fashion. The medulla consists of chromaffin cells arranged in groups or anastomosing cords. The two adrenal glands are situated retroperitoneally, each embedded in perirenal fat above its respective kidney. In the adult, the average weight is 5 gm., and the range is 4 to 14 gm. The gland usually is heavier in males than in females.

PHYS: The adrenal medulla synthesizes and stores three catecholamines: dopamine,

adrenal gland

41

adrenal gland



norepinephrine, and epinephrine. Dopamine's chief effects are dilation of systemic arteries, increased cardiac output, and increased flow of blood to the kidneys. The primary action of norepinephrine is to constrict the arterioles and venules with resulting increased resistance to blood flow, elevated blood pressure, and slowing of the heart. Epinephrine constricts vessels in the skin and splanchnic area, dilates vessels in skeletal muscle, increases heart activity, dilates the bronchi by relaxing bronchial musculature, increases level of glucose in the blood by stimulating the production of glucose from glycogen in the liver, increases the amount of fatty acid in the blood, and diminishes activity of the gastrointestinal system. The three catecholamines are also produced in other parts of the body.

The adrenal medulla is under the control of the sympathetic nervous system and functions in conjunction with it. It is intimately related to adjustments of the body in response to emotional states. Anticipatory states tend to bring about the release of norepinephrine. More intense emotional reactions, esp. those in response to extreme stress, tend to increase the secretion of both norepinephrine and epinephrine. Epinephrine is important in mobilizing the physiological changes that occur in the "fight or flight"

response to emergency situations.

The cortex secretes a group of hormones that vary in quantity and quality. They are all synthesized from cholesterol and contain the basic steroid nucleus perhydrocyclohexanoperhydrophenanthrene. These compounds are grouped according to their chemical structure and biological activity as follows: glucocorticoids (cortisol, corticosterone), which act principally on carbohydrate metabolism; mineralocorticoids (aldosterone, dehydroepiandrosterone), which affect metabolism of the electrolytes sodium and potassium; androgens (17-ketosteroids), estrogens (estradiol), and progestins (progesterone), all three of which are important in the physiology of reproduction. There is considerable overlap in the biological activity of many of these compounds. SEE: steroid.

Almost all body systems are influenced by the action of adrenocortical hormones. Cortisol and cortisone are important in carbohydrate, water, muscle, bone, central nervous system, gastrointestinal, cardiovascular, and hematological metabolism. They are also important anti-inflammatory agents. The principal long-term effect of cortisone and cortisol is catabolic.

The 17-ketosteroids act principally as androgenic and anabolic agents. Aldosterone's principal action is to control sodium and potassium levels in the blood.

PATH: In the medulla, increased secretion of catecholamines occurs when a pheochromocytoma develops. In this condition, the patient develops hypertension, excessive sweating, paroxysmal attacks of blanching or flushing of the skin, tachycardia, headache, anorexia, weight loss, personality changes, signs of increased metabolism, constipation, and postural hypotension. Diagnosis may be confirmed by determining the level of catecholamines or their metabolic end-products in the urine. SEE: pheochromocytoma.

In the cortex, when excess secretion of cortical hormones occurs, one of a variety of syndromes may result, depending upon which hormones or group of hormones are increased. If cortisol is increased, the signs of Cushing's syndrome result: obesity with striae and redistribution of fat to produce a "buffalo hump" and "moon face," muscle wasting, osteoporosis, decreased glucose tolerance, atherosclerosis, and systolic hypertension. If the androgens are increased, male sex characteristics are accentuated in the female with voice change, hirsutism, clitoral enlargement, and pronounced muscular development. Baldness and acne will develop in either sex with this condition. It is termed adrenogenital syndrome, q.v.

Provoked 2 million times per
YEAR. Developed after 4 years,
now 9.

b

adrenal gland

The two adrenal glands are situated next to the kidneys and their main function is to release body regulating chemicals in response to nerve signals generated by the autonomic nervous system (ANS). The Autonomic nervous system regulates automatic bodily functions such as heart beat, automatic breathing, dilation of blood vessels in response to heat and many other functions that we are seldom aware of. The adrenal glands are "plugged into" a sub-division of the ANS called the sympathetic nervous system.

The adrenal glands are organised into an inner medulla and an outer cortex.

The medullae are richly innervated with sympathetic nerve fibres and release regulatory biochemicals in response to sympathetic nervous signals such as emotional excitement, fear, apprehension, psychic distress, panic reactions, sexual activity and fight-or-flight stimuli. These biochemicals are called catecholamines and include epinephrine (adrenaline) and norepinephrine and they prepare many parts of the body for the appropriate responses to such signals.

The cortices release a class of biochemicals called steroid hormones, in particular glucocorticoids and mineralocorticoids among others. Glucocorticoids play a very important regulatory function and there are few cells in the entire body that do not have glucocortico-receptors. With respect to the immune system, glucocorticoids act as anti-inflammatory and immunosuppressive agents and are widely used in autoimmune diseases including multiple sclerosis.

A hormone responsible for regulating natural bodily glucocorticoids, adrenocorticotrophic hormone (ACTH) used to be used to control MS relapses. Its use has now largely been replaced by synthetic Methylprednisolone.

Adrenal Gland: Introduction and Index

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[Endocrine Index](#)

[Glossary](#)

● The Adrenal Gland: Introduction and Index

When you think about the adrenal glands, you should think about stress. Stress can take many forms: taking an examination, recovering from a broken bone, running away from an invading army, or maintaining proper levels of energy substrates in the face of even mild starvation. For human males, there is even considerable stress associated with shopping.

The adrenal produces three major classes of hormones, each of which aid in dealing with the multitude of small and large stresses faced by animals and people almost daily. There is no doubt that at least two of these groups - glucocorticoids and mineralocorticoids - are necessary for life.

Ch. 280 Autonomic Drugs—Physiology of the Autonomic Nervous System 2347

TABLE 280-1. RESPONSES OF EFFECTOR ORGANS TO AUTONOMIC NERVE IMPULSES

Effector Organs	Adrenergic Impulses		Cholinergic Impulses
	Receptor Type	Responses*	Responses*
Eye			
Radial muscle, iris	α	Contraction (mydriasis) ++	
Sphincter muscle, iris			Contraction (miosis) ++
Ciliary muscle	β	Relaxation for far vision +	Contraction for near vision +++
Heart			
S-A node	β_1	Increase in heart rate ++	Decrease in heart rate; vagal arrest +++
Atria	β_1	Increase in contractility and conduction velocity ++	Decrease in contractility, and (usually) increase in conduction velocity ++
A-V node	β_1	Increase in automaticity and conduction velocity ++	Decrease in conduction velocity; A-V block ++
His-Purkinje system	β_1	Increase in automaticity and conduction velocity +++	Little effect
Ventricles	β_1	Increase in contractility, conduction velocity, automaticity, and rate of idioventricular pacemakers ++	Slight decrease in contractility claimed by some
Arterioles			
Coronary	α, β_2	Constriction +; dilatation ± ++	Dilatation ±
Skin and mucosa	α	Constriction ++	Dilatation ±
Skeletal muscle	α, β_2	Constriction ++; dilatation ± ++	Dilatation ** +
Cerebral	α	Constriction (slight)	Dilatation ±
Pulmonary	α, β_2	Constriction +; dilatation ±	Dilatation ±
Abdominal viscera; renal	α, β_2	Constriction ++; dilatation ± +	
Salivary glands	α	Constriction ++	
Veins (systemic)	α, β_2	Constriction ++; dilatation + +	
Lung			
Bronchial muscle	β_2	Relaxation +	Contraction ++
Bronchial glands	?	Inhibition (?)	Stimulation ++
Stomach			
Motility and tone	α, β_2	Decrease (usually) ++ +	Increase ++
Sphincters	α	Contraction (usually) +	Relaxation (usually) +
Secretion		Inhibition (?)	Stimulation ++
Intestine			
Motility and tone	α, β_2	Decrease ++ +	Increase ++
Sphincters	α	Contraction (usually) +	Relaxation (usually) +
Secretion		Inhibition (?)	Stimulation ++
Gallbladder and ducts			
Kidney			
Urinary bladder	β_2	Relaxation +	Contraction +
Detrusor	β	Renin secretion ++	
Trigone and sphincter	α	Relaxation (usually) +	Contraction + + +
		Contraction + +	
		Relaxation ++	

(Continued)

2348 Autonomic Drugs—Physiology of the Autonomic Nervous System

TABLE 280-1. RESPONSES OF EFFECTOR ORGANS TO AUTONOMIC NERVE IMPULSES (Cont'd)

Effector Organs	Adrenergic Impulses		Cholinergic Impulses
	Receptor Type	Responses*	Responses*
Ureter Motility and tone	α	Increase (usually)	Increase (?)
Uterus	α, β_2	Pregnant, contraction (α); nonpregnant, relaxation (β)	Variables §§
Sex organs, male	α	Ejaculation + + +	Erection + + +
Skin			
Pilomotor muscles	α	Contraction + +	
Sweat glands	α	Localized secretion *** +	Generalized secretion + + +
Spleen capsule	α, β_2	Contraction + + +; relaxation +	
Adrenal medulla			
Liver	α, β_2	Glycogenolysis, gluconeogenesis †††	Glycogen synthesis +
Pancreas			
Acini	α	Decreased secretion +	Secretion + +
Islets (β cells)	α β_2	Decreased secretion + + + Increased secretion +	— —
Fat cells	α, β_1	Lipolysis ††† + + +	
Salivary glands	α β	Potassium and water secretion + Amylase secretion +	Potassium and water secretion + + +
Lacrimal glands			
Nasopharyngeal glands			Secretion + + +
Pineal gland	β	Melatonin synthesis	Secretion + +

* Responses are designated 1+ to 3+ to provide an approximate indication of the importance of adrenergic and cholinergic nerve activity in the control of the various organs and functions listed.

† Dilatation predominates *in situ* due to metabolic autoregulatory phenomena.

‡ Cholinergic vasodilatation at these sites is of questionable physiological significance.

§ Over the usual concentration range of physiologically released, circulating epinephrine, β -receptor response (vasodilatation) predominates in blood vessels of skeletal muscle and liver; α -receptor response (vasoconstriction), in blood vessels of other abdominal viscera. The renal and mesenteric vessels also contain specific dopaminergic receptors, activation of which causes dilatation, but the physiological significance has not been established (see review by Goldberg et al., 1978).

** Sympathetic cholinergic system causes vasodilatation in skeletal muscle, but this is not involved in most physiological responses.

†† It has been proposed that adrenergic fibers terminate at inhibitory β receptors on smooth muscle fibers, and at inhibitory α receptors on parasympathetic cholinergic (excitatory) ganglion cell of Auerbach's plexus.

§§ Depends on stage of menstrual cycle, amount of circulating estrogen and progesterone, and other factors.

*** Palms of hands and some other sites ("adrenergic sweating").

††† There is significant variation among species in the type of receptor that mediates certain metabolic responses.

Adapted from "Drugs Acting at Synaptic and Neuroeffector Junctional Sites," pp. 60, 61, in GOODMAN AND GILMAN'S THE PHARMACOLOGICAL BASIS OF THERAPEUTICS, ed. 6, 1980, edited by A. G. Gilman, L. S. Goodman, and A. Gilman. Copyright © 1980 by Macmillan Publishing Co., Inc. Use with permission.

Exhibit B

CLINICAL NEUROPHYSIOLOGY LABORATORY
PERINEAL EMGAcct. # 0022002MR# 0022002Name: Collen HardeckerDate: (12/6/04)

12/13/04

Anal WinkL- (present, absent)R- (present, absent)Perineal Sensation

L- intact

R- intact

2nd EMG

Showing-

no difference

between

rest + Squeezed

(Contracted)

much worse than 2001

Digital Exam:

Quadrants

	L. Anterior	L. Posterior	R. Anterior	R. Posterior
At Rest	NL	↓	NL	NL
Volitional Contraction	↑ tone	No Δ	No Δ	No Δ
Reflexive Contraction (cough)	↑ tone	No Δ	↑ tone	No Δ
With Pushing (as to defecate)	No Δ	No Δ	No Δ	No Δ

EMG:

Quadrants

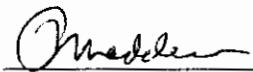
	L. Anterior	L. Posterior	R. Anterior	R. Posterior
At Rest	≤ 1/2 NL pattern (+) Polysynthetic	- rare PSS/ER (+) Polysynthetic - scant pattern	(+) PSS/ER (+) Polysynthetic - scant	- rare PSS/ER (+) Polysynthetic NL interkinetic pattern
Volitional Contraction	1/2 full	1 3/4	1 to 1 1/2	1 to 30% full
Reflexive Contraction (cough)	↑ to 3/4	1 to 3/4	1 to 1 1/2	1 to 50% full
With Pushing (as to defecate)	No Δ from testing	1 to 1 1/2	No Δ from rest	No Δ from rest

Patient:	Hardacre,Collen	12/13/04
I.D. #:	33g	

Impression

This is an abnormal neurophysiological study. The patient has evidence of:

- 1) Peripheral paralysis of the anal sphincter with both acute and chronic changes. Such findings can be consistent with both urinary and fecal lower motor neuron incontinence/complaints.
- 2) Mild, central paralysis of the anal sphincter affecting the anterior quadrants only, implying an UMN problem. Clinical correlation and cervical and thoracic neuroimaging is therefore here recommended.



Patrick J. Madden, M.D.

18

BOSTON NEUROLOGICAL P.C.
PATRICK J. MADDEN, M.D.
BOARD CERTIFIED NEUROLOGIST

792 Southern Artery
Quincy, MA 02169

New England Baptist Hospital
125 Parker Hill Avenue
Boston, MA 02120

Telephone: 617-786-9330
Fax: 617-786-1591

FOLLOW-UP OFFICE VISIT

Name: Colleen M. Hardcore

Date of Birth: 12/16/60

11/16/04

Time: @ 9:00 AM

Referring Physician: Dr. Kornoff (Lobey)

Sensitivity: Penicillin, Nitrofurantoin, IVP-dye, CT-dye

Medications:

none

She was 330

- Lost 100#

Last seen 5/30/03

SPAMS
Urinary urgency
Urinary frequency
Urinary urge

Current Status:

She - On adrenergic now because so upset. Feels FBG sending her
"PEAK" - weeks. Pt notes the pelvic exam is much worse
Last week she felt a pull which was like a tear
she per urinated Blood? She went to the ER which was
diagnosed as a bladder infection. She was given an antibiotic
which helped. She feels "they" per se provoke
her causing adrenergic to release which cause her
spasms to get worse.
She does not feel "down there" urine & stool affected
Sleep: Better. No problem getting/staying asleep, lately.

Neurological Exam:

- AA, mildly dysphoria, DTRs, no language
- atrophy midline T-1 - paraspinal muscles; mild power loss
- mildly tight / tender upper l- paraspinal muscles; tended MRC 3-4/5
- Romberg (gn); nl. regular gait (? mildly antalgic)
- tended elongation of femur

Diagnosis:

- ① Known Neurogen (L MN) Bladder/ bowel
- ② ? Central (VMN) Bladder (+ or bowel)
- ③ ↓ Sleep - better

Plan:

→ Valsalva 25mg propranolol muscle spasm → dry lots (Glycetteb/CFP, hemicyclone)
→ T-Spine MRI (2/5 grade) → oral sphincter use

Signature: Patrick J. Madden, M.D.

Time: @ 9:50 AM

QUINCY MEDICAL CENTER

114 WHITWELL ST. BOSTON ** QUINCY, MASSACHUSETTS 02169

EMG DEPARTMENT

EMG/NERVE CONDUCTION REPORT

PATIENT'S NAME: HARDACRE, COLLEEN

DATE DICTATED: 04/04/01

ACCOUNT NUMBER: F17856782

UNIT NUMBER: M0407342

ORDERING PHYSICIAN:

AGE: 40 SEX: F

DICTATING PHYSICIAN: MADDEN, PATRICK

ORDER DATE:

I Sf
 EMG
 showing
 Contracted
 tone
 2001

*** HISTORY ***

The patient is seen by me in neurological consultation for low back pain. The patient reported a history of urinary urgency and frequency as well as fecal urgency and frequency and occasional urinary incontinence.

The patient is having a perineal EMG to assess for possible neurogenic cause to her problems.

On digital examination, the patient had normal sensation appreciated bilaterally. The patient had absent anal wink reflexes bilaterally. At rest, the right posterior quadrant of the anal sphincter appears to have normal tone. Otherwise the other three quadrants of the anal sphincter appear to be lax. With both volitional contraction of the anal sphincter as well as with reflexive contraction of the anal sphincter (i.e., as seen with coughing), no change from the resting tone is appreciated for the left anterior, left posterior and right anterior quadrants. A slight increase in tone is appreciated for the right posterior quadrant with both volitional contraction and reflexive contraction of the anal sphincter. With pushing (as to defecate) no change from the resting tone is appreciated for all four quadrants.

*** SUMMARY ***

Perineal EMG recording was performed by using monopolar needle EMG inserted into the four quadrants of anal sphincter. At rest, there is the normal resting sustained firing of motor units seen for only the left anterior quadrants. However, acute denervation changes were seen including positive sharp waves for the left anterior quadrant. Polyphasic units were also seen. With needle insertion of the left and right posterior quadrants, half of the normal resting sustained firing motor units is seen. Polyphasia is also seen, but no acute denervation changes are appreciated. Polyphasia is also seen with sampling of the right anterior quadrant. There is only 1/4 of the normal resting sustained firing motor units seen for the right anterior quadrant. With volitional contraction of the anal sphincter a full interference pattern is appreciated for only the right posterior quadrant. For the other three quadrants of the anal sphincter, 3/4th's of a full interference pattern is appreciated with volitional contraction. Reflexive contraction at the anal sphincter (as seen with coughing) gives results for all four quadrants identical to that seen with volitional contraction. With pushing, as to defecate, no change from the resting sustained firing of motor units are seen for the left anterior quadrant, right anterior quadrant and the right posterior quadrant. An inappropriate increase in the interference pattern is appreciated with sampling of the left posterior quadrant of the anal sphincter to 3/4th's of a full interference pattern.

*** IMPRESSION ***

This is an abnormal neurophysiological study of the perineal region. The above findings are consistent with:

1. A peripheral paralysis of the anal sphincter with acute denervation changes seen

Run: 04/25/01-1106 by BRADSHAW, CYNTHIA

only with sampling of the left anterior quadrant, but with chronic denervations seen in all four quadrants. With attempt at defecation, there is an increase in activity seen for the left posterior quadrants which implies an inappropriate paradoxical recruitment of motor units representing aberrant regeneration.

There is no evidence of a central paralysis of the anal sphincter here, given the fact that there should be a relative decrease and voluntary discharges seen with relative preservation of reflexive activation. Clinical correlation is therefore recommended here.

Patrick J. Maden?

04/04/01 1023
BARILLARO, EILEEN
HARDACRE, COLLEEN
M0407342

0405-0001

Run: 04/25/01-1106 by BRADSHAW, CYNTHIA

OP NOTE

LC# : 000002266723

PRINTED ON : 05/22/05 1046

BY : MRKXB00 SU53

20030331HARDACRE, COLLEEN

** NOTE: THE FINAL SIGNED COPY OF THIS DOCUMENT IS FILED IN THE
** PATIENT MEDICAL RECORD AND MAY VARY FROM THIS COPY **

LAHEY CLINIC MEDICAL CENTER - Burlington, MA.
GYN

NAME: HARDACRE, COLLEEN
DATE: 03/31/2003
LCMC NO.: 2266723

NAME: HARDACRE, COLLEEN
LC#: 2266723
ADMISSION DATE: 03/31/03
DISCHARGE DATE: / /

SURGEON: Alison B. Dick, MD
ASSISTANT:

PREOPERATIVE DIAGNOSIS: ADENOMATOUS HYPERPLASIA.

POSTOPERATIVE DIAGNOSIS: ADENOMATOUS HYPERPLASIA, PENDING
PATHOLOGY.

NAME OF PROCEDURE: HYSTEROSCOPY; DILATATION AND CURETTAGE.

ANESTHESIA: Spinal, then general.

INDICATIONS: This 42-year-old multiparous woman with long period of irregular bleeding underwent office endometrial biopsy at another institution that revealed adenomatous hyperplasia with a question of atypia. Therefore, hysteroscopy with D&C was advised.

OPERATIVE FINDINGS: Enlarged, anteverted uterus with moderate amount of tissue in the endometrial cavity. No obvious polyps. No submucous fibroids.

DESCRIPTION OF PROCEDURE: The patient was brought to the operating room and a spinal anesthetic administered. She was placed in dorsal lithotomy position and prepped and draped in the usual fashion for D&C.

Examination under anesthesia revealed an anteverted, enlarged uterus and nonpalpable adnexa. A bivalved speculum was placed in the vagina and the anterior lip of the cervix grasped with a single-tooth tenaculum. The cervical os was dilated to #18 Pratt dilator. The patient began to experience some cramping during the dilatation procedure. The uterus was then sounded to 12 cm. At this point, it was clear that the patient was uncomfortable with entry into the uterus. An LMA was given for general anesthesia.

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The hysteroscope was placed in the cervical canal and, with lactated Ringer's installation, advanced to the fundus. The tubal ostium on the right was clearly seen. The tubal ostium on the left was seen with some difficulty due to the amount of endometrial tissue. No obvious polyps and no submucous fibroids were appreciated. The hysteroscope was removed.

The cervical os was dilated to a #22 Pratt dilator. Sharp curettage of the uterine cavity revealed a moderate amount of curettings. There were no irregularities of the uterine cavity consistent with fibroid.

The tenaculum was removed from the cervix and the speculum removed from the vagina. The patient tolerated the procedure well with minimal blood loss and fluid deficit of 50 cc. She was brought to the recovery room in stable condition.

Alison B. Dick, MD

DOD: 3/31/2003 MW712/3135712/4315233
DOT: 3/31/2003 1743

===== END OF DOCUMENT =====

LC# : 000002266723

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20050303HARDACRE, COLLEEN

LAHEY CLINIC MEDICAL CENTER - Burlington, MA.
GYNNAME: HARDACRE, COLLEEN
DATE: 03/03/2005
LCMC NO.: 2266723

GYNECOLOGY

HARDACRE, COLLEEN 03/03/2005 LC# 2266723
DOB: 12/06/1960

Ms. Hardacre is a 44-year-old G2 SAB 1 TAB one white female who comes for annual examination, Pap smear and discussion of spasm in the pelvic muscles. The patient states that she feels spasm and pulling sensation in the bladder, vaginal and rectal area. An EMG was done recently and spasm was confirmed by her neurologist who prescribed Valium to be used p.r.n. The patient states she has been unable to have coitus for three years, but later in the interview admits to coitus in the past two weeks. Her periods are normal once a month with a normal flow. She denies heavy flow, cramps or intermenstrual bleeding. She was treated for urinary tract infection recently, but has no bladder symptoms. She states that it is difficult to move her bowels because of spasm in the rectal area.

PAST OB/GYN HISTORY: Dilatation and curettage by Dr. Alison Dick March 2003 when simple hyperplasia was diagnosed. She was treated with Prometrium but stopped this medication due to fluid retention.

PAST MEDICAL HISTORY: Positive for morbid obesity, sleep apnea, atypical chest pain and schizoaffective disorder. *-(not)
REF is doing those things*

CURRENT MEDICATIONS: None.

ALLERGIES: Cipro, penicillin, contrast dye.

DATA: Last Pap smear was July 2004 but was inadequate due to lack of cellularity.

PHYSICAL EXAMINATION: Physical exam today shows an anxious overweight white female with fast speech. Height is 5 feet 6 inches. Weight is 261 pounds. *-Reds
Red
30 pounds* Blood pressure 130/80. Abdomen is soft and nontender without masses. External genital exam appears normal. Speculum exam shows a normal vaginal mucosa without lesions, bleeding or discharge. Cervix is nulliparous and normal in appearance without lesions. A Pap smear is obtained there is some friability of the cervix after the Pap. Bimanual examination reveals no abnormalities in the Bartholin's, urethral and Skene's glands. The urethra and bladder are nontender there is marked spasm in the levator muscles which are slightly tender to touch. The cervix is well supported and nontender. Uterus and adnexa are not well palpated due to the patient's obesity, but there is no tenderness or mass noted. Rectal exam confirms

===== CHART NOTE =====

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high tone, no lesions and no pelvic masses.

ASSESSMENT:

1. 44-year-old para zero white female with regular menses, and complaints of vaginismus and dyspareunia.
2. Past history of simple hyperplasia treated with Prometrium.

PLAN: Pap smear was obtained today. The patient will be notified of these results. She was advised to return if her menstrual pattern became abnormal so that a further evaluation could be initiated. Regarding the discomfort with intercourse she was advised to use condoms and lubrication and to engage in foreplay designed to relax the spasm in the vaginal area if she wants to become sexually active. The patient will return on an as needed basis or for regular checkups.

Mary H. Briggs, MD
781-744-8564

MHB:kvm
D: 03/03/2005 11:22:08
T: 03/06/2005 22:33:31
J: 4648990

CC:

Matthew S Kanef, MD, <Primary Care Physician>

THIS DOCUMENT WAS ELECTRONICALLY AUTHENTICATED BY Mary H. Briggs, MD ON
03/07/2005 14:50:41

===== END OF DOCUMENT =====

===== PHONE NOTE =====
LC# : 000002266723PRINTED ON : 05/22/05 1045
BY : MRKXB00 SU53

20050321HARDACRE, COLLEEN

LAHEY CLINIC BURLINGTON
GYNNAME: HARDACRE, COLLEEN
DATE: 03/21/2005
LCMC NO.: 2266723TELEPHONE MEMORANDUM
GYNECOLOGYHARDACRE, COLLEEN 03/21/2005 LC# 2266723
DOB: 12/06/1960
Visit ID: PC2266723

I spoke with this patient by telephone today to discuss her Pap smear results. Pap smear obtained 3/3/05 was read as satisfactory, but with obscuring blood. It was described as a menstrual sample with atypical glandular cells present. The report did not specify the source of the glandular cells. High risk HPV testing is negative. I explained to the patient that further testing is necessary at this point, and she may have a recurrence of hyperplasia that was diagnosed two years ago by D&C. The patient was treated with Prometrium at that time, but stopped due to fluid retention. The patient was anxious about having office procedures that might be uncomfortable. I recommended that she take a Valium and several Advil prior to her next appointment, and further advised her that I could use a local anesthetic at her next visit, during which I plan to do endocervical curettage and endometrial biopsy. She expressed understanding and agreement and will call the appointment office to schedule a follow up visit.

Mary H. Briggs, MD
781-744-8564MHB:kat
D: 03/21/2005 17:17:16
T: 03/24/2005 16:07:07
J: 4688307

CC:

THIS DOCUMENT WAS ELECTRONICALLY AUTHENTICATED BY Mary H. Briggs, MD ON
03/28/2005 09:19:30

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BY : MRKXB00 SU53

20050428HARDACRE, COLLEEN

LAHEY CLINIC MEDICAL CENTER - Burlington, MA.
GYNNAME: HARDACRE, COLLEEN
DATE: 04/28/2005
LCMC NO.: 2266723

GYNECOLOGY

HARDACRE, COLLEEN 04/28/2005 LC# 2266723
DOB: 12/06/1960
Visit ID : 15318887

HISTORY OF PRESENT ILLNESS: Ms. Hardacre is a 44-year-old para 0 white female who presents for evaluation of abnormal Pap smear. In March 2005 Pap smear was obtained at the end of the patient's period and showed atypical glandular cells with negative high-risk HPV testing. The patient does have a history of hyperplasia that was diagnosed two years ago by dilatation and curettage. This was treated with Prometrium but stopped due to weight gain. Her periods are normal without heavy flow, cramps or intermenstrual bleeding.

PAST OB/GYN HISTORY: One miscarriage, one abortion, dilatation and curettage in March 2003 showing simple hyperplasia, morbid obesity, sleep apnea, atypical chest pain and schizoaffective disorder.

ALLERGIES: Cipro, penicillin, contrast dye.

PHYSICAL EXAM: Shows weight of 270. Height of 5' 5". Blood pressure 140/90 in this anxious overweight white female. After verbal informed consent endometrial biopsy is performed. Speculum is inserted and the cervix is easily visualized. Repeat Pap smear is obtained and the cervix is prepped with Betadine and endocervical curettage was performed and the specimen collected with a Cytobrush. A 3 mm Pipelle is passed 8 cm into the uterine cavity and uterus is thoroughly sampled. The specimen was sent to pathology. The patient tolerated the procedure well despite severe anxiety.

ASSESSMENT: 44-year-old P zero obese white female with history of AGUS on Pap smear recently, evaluated today with repeat Pap smear, endocervical curettage and endometrial biopsy.

PLAN: The patient is advised to return in two weeks for discussion of test results and recommendations.

Mary H. Briggs, MD
781-744-8564

MHB:mg
D: 04/28/2005 10:28:27
T: 05/04/2005 15:49:23

===== CHART NOTE =====

LC# : 000002266723

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BY : MRKXB00 SU53

J: 4776192

CC:

Matthew S Kanef, MD, <Primary Care Physician>

THIS DOCUMENT WAS ELECTRONICALLY AUTHENTICATED BY Mary H. Briggs, MD ON
05/05/2005 12:52:27

===== END OF DOCUMENT =====

FINAL Gyn Cytology Report

Name: HARDACRE, COLLEEN

Case: G2005-004774

Source

CERVIX-THINPREP

Adequacy

SATISFACTORY FOR INTERPRETATION.

SATISFACTORY BUT WITH OBSCURING BLOOD.

Interpretation

CERVIX-THINPREP

MENSTRUAL SAMPLE WITH ATYPICAL GLANDULAR CELLS PRESENT (AGUS).
 THE SPECIMEN WILL BE EVALUATED FOR HIGH RISK HPV (HUMAN PAPILLOMA VIRUS) TYPES. FINAL RESULTS OF THIS ASSAY WILL BE REPORTED FROM THE MICROBIOLOGY LAB IN 2-3 WEEKS.

(jd[lsk])

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P
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R
T

Electronic Signature

THEODORA A. GUTSELL, C.T (ASCP)
 (Case Screened 03 11 2005)

JOHN M. DUGAN, M.D.
 (Case signed 03 14 2005)

Case Clinical Information

ANNUAL
 PREVIOUS ABNORMAL PAP
 ROUTINE

Physicians

BRIGGS,MARY H./8564/1099

Cervicovaginal cytology ("Pap Smear") is a screening test intended to aid in the detection of cervical squamous cell carcinoma and its precursors. Although very effective, the test is imperfect with a well recognized false positive and false negative fraction. The false negative fraction has been reported in the literature to be at least 5-10%.

LAHEY CLINIC BURLINGTON, MA 01805 (781) 744-8046 GYN CYTOLOGY REPORT	HARDACRE, COLLEEN MARY H. BRIGGS, M.D. DOB: 12 06 1960 ORDERED: 03 03 2005 RECEIVED: 03 04 2005	2266723 LOC: 6WC AGE/SEX: 4/ F REPORTED: None SITE:
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